# Overview of the Mental Health Service System for Criminal Justice Professionals

Jackie Massaro, MSW

**Published by:**
**Technical Assistance and Policy Analysis Center for Jail Diversion**

TAPA

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

# Overview of the Mental Health Service System for Criminal Justice Professionals

Jackie Massaro, MSW

March 2005

DRAFT

This work was conducted under support to the SAMHSA-funded Technical Assistance and Policy Analysis Center for Jail Diversion, one of two centers comprising the National GAINS Center.

The author wishes to thank C. Terence McCormick of Cares, LLC, for his invaluable assistance with this monograph.

The suggested citation for this monograph is Massaro, J. (2005). *Overview of the Mental Health Service System for Criminal Justice Professionals*. Delmar, NY: GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.

# TABLE OF CONTENTS

# Introduction

The criminal justice and mental health service systems appear to meet very different societal needs, yet they overlap in two significant ways. First, they both seek to maintain the safety of the people in the community; second, both systems work with the same individuals.

This publication provides criminal justice professionals with basic information about the adult mental health service system, and it highlights some of the common challenges for the mental health and criminal justice service systems in meeting the needs of adults with mental illness. It is intended as a reference for judges and other court personnel, attorneys, jail services, prison services, diversion programs, probation departments, parole services, alternative to incarceration programs, and law enforcement. The GAINS Technical Assistance and Policy Analysis Center for Jail Diversion (TAPA), has made available a companion monograph for mental health service providers, *Working with People with Mental Illness Involved with the Criminal Justice Systems: What Mental Health Service Providers Need to Know* (Massaro, 2004), which may be useful to providers that fill both criminal justice and mental health roles. In addition, the Bureau of Justice Assistance Mental Health Court Grant Program is scheduled to release a brief entitled, *Navigating the Mental Health Maze: A Guide for Court Practitioners*, which provides more in-depth information about the treatment of mental illness (Osher & Levine, 2005).

***People with serious mental illness can recover and live meaningful lives as productive members of the community (Jacobson & Greenley, 2001; U.S. Department of Health and Human Services, 2000; President's New Freedom Commission on Mental Health, 2003)***

**Recovery from mental illnesses can be achieved.** People with serious mental illness can recover and live meaningful lives as productive members of the community (Jacobson & Greenley, 2001; U.S. Department of Health and Human Services, 2000; President's New Freedom Commission on Mental Health, 2003). Recovery is a process through which people find ways to relieve the symptoms of mental illness; learn to reduce the severity and recurrence of symptoms; develop self-care practices; and find meaningful social roles through family life, employment, or other activities (Jacobson & Greenley, 2001). For the person with mental illness, recovery involves regaining hope and finding the courage to pursue wellness.

**Partnerships with consumers in planning for recovery.** Criminal justice and mental health professionals can play an important role in supporting recovery. While allowing each person to progress in his or her own way often requires patience,

professionals can support recovery by remaining optimistic; conveying a message of hope (Deegan, 1988); and focusing on the individual's strengths, resilience, and successes. Initially these successes may be incremental.

"Partnership" refers to working together with people to assist them in planning for their own recovery. One of the best ways to facilitate peoples' participation in mental health services and positive decision making is to respect the right to self-determination and choice. People with mental illness can and should make their own decisions, as long as these choices do not interfere with the rights of others or the law. Professionals can assist people in decision making by helping to clarify the advantages and disadvantages or positive and negative consequences of various actions (e.g., drug use, participating in treatment, and taking medication).

Criminal justice and mental health professionals have a responsibility to protect the community and people with mental illness. *If* symptoms of mental illness result in danger to self or others, preventive steps will be necessary. In anticipation of the possibility of such a crisis with a given individual, criminal justice and mental health professionals can plan ahead with the person to avoid or manage crisis situations.

These types of partnerships can help criminal justice and mental health professionals balance responsibilities for public safety with the needs of the individual.

**People with mental illness become involved with the criminal justice system for a variety of reasons.** The symptoms of mental illness may result in bizarre or unusual behaviors that are disturbing to other people and result in complaints to law enforcement. A lack of understanding on the part of the general public about mental illness often leads people to perceive behaviors associated with mental illness as frightening or threatening. Individuals with mental illness in the community may display these disconcerting symptoms if they are not receiving any treatment or if they are not participating fully in treatment (i.e., not attending therapy, not taking medications). For a variety of reasons, people with mental illness are not always willing to participate in treatment. The illness itself may make some people fearful of authority figures or of being controlled; others may object to the treatments offered. Mental health providers are challenged to find ways to engage these individuals and to create (or adjust) treatment plans that keep people involved in treatment.

People with mental illness may also become involved with the criminal justice system due to aggressive behavior. To date, research concludes that only a weak association exists between mental illness and violence in the community (MacArthur Research Network on Mental Health and the Law, 2004). However, under certain circumstances, a person with mental illness may be at greater risk for exhibiting aggressive or violent behavior that must be sanctioned. The symptoms of mental illness alone do not necessarily increase risk; however risk increases with the presence of certain other factors, the most significant being the use of alcohol or other drugs. Other factors that increase risk include a history of violence; anger; violent fantasy; and psychopathy, a disorder characterized by the lack of concern for other people and impulsive behavior (Monahan et al., 2001).

Of course for some people, mental illness is secondary to involvement in criminal behavior. For example, co-occurring substance use disorders result in illegal activities such as possession or sale of controlled substances or crimes of opportunity to support substance abuse.

The presence of a mental illness does not necessarily prevent people from acting in a responsible and socially adaptive manner. However, the symptoms of mental illness may interfere with social functioning; treatment of these symptoms can help to restore responsible social behavior. Responsibility for criminal behavior should not be automatically excused due to the presence of mental illness (Rotter et al., 1999).

**When people with mental illness become involved with the criminal justice system, it can create a strain on system resources.** Nonviolent incidents perpetrated by people with mental illness often lead to burgeoning court dockets and jail overcrowding. While in jail, people with mental illness have a right

to treatment and may require expensive medications and other mental health services. Further, these people may require frequent attention from corrections officers because the symptoms of mental illness are often accompanied by confusion and unusual or disruptive behavior. (This behavior is often misunderstood by corrections officers, who may respond by charging infractions, which incur additional punishment in some form.) The stress of incarceration can exacerbate symptoms and can lead to mental health crises, requiring costly intervention measures. Mental illness also can interfere with a person's ability to meet obligations to the courts or to community corrections programs, which can result in re-arrest and lengthy procedures to initiate violations of probation, parole, or other court orders. The extra time and attention required by persons with mental illness in the justice system can be very costly.

**The report of the President's New Freedom Commission on Mental Health has noted the need to address mental health problems in the criminal justice system.** The report encourages the development and implementation of diversion programs, the adoption of established guidelines for mental health care in correctional settings, and the expansion of re-entry programs (President's New Freedom Commission on Mental Health, 2003).

- Many individuals with mental illness report that their mental illness was first identified in jail or prison or that uncontrolled symptoms contributed to criminal behavior. The New Freedom Commission recognizes that the criminal justice system too often becomes the primary source of mental health care and suggests diverting these individuals to "more appropriate and typically less expensive supervised community care." Diversion programs can involve these individuals in treatment and rehabilitation, helping them to become successful, contributing members of their communities.
- The provision of appropriate mental health care in jail or prison can alleviate symptoms and restore the person to a higher level of functioning.

***The New Freedom Commission recognizes that the criminal justice system too often becomes the primary source of mental health care and suggests diverting these individuals to "more appropriate and typically less expensive supervised community care."***

- Persons with mental illness returning to their communities from jail and prison face stigma and discrimination due not only to their mental illnesses but to their criminal records. They face the twin burdens of managing their mental illness and re-entry into society. Specialized re-entry strategies that link people with mental illness to services can ease the transition back to community life and help prevent relapse or recidivism.

**In many locations, the criminal justice and mental health service systems are creating partnerships to alleviate these problems.** Cooperative ventures between the criminal justice and mental health systems can be found at many levels where the two systems work with the same individuals. Such ventures include the training of police officers to intervene in mental health crisis situations; the training of corrections officers to identify and intervene with mental health problems in jails and prisons; and the provision of diversion programs to redirect individuals from the criminal justice system to the mental health system, alternative to incarceration (ATI) programs, and community correctional services that pair sanctions with therapeutic services.

***Cooperative ventures between the criminal justice and mental health systems can be found at many levels where the two systems work with the same individuals.***

To achieve effective partnerships, the professionals in each system must develop some basic understanding of the other system:

- its purpose
- responsibilities and functions of various system components
- roles and responsibilities of various professionals
- policy and procedures in areas in which the systems overlap, and
- some of the system's professional terminology to facilitate communication.

## Fact or Fiction? Understanding Mental Illness

**Fiction:** People with mental illness have diminished intelligence.

**Fact: The presence of mental illness does not diminish an individual's intellectual capacity.** At times when a person is experiencing an episode of severe symptoms (such as high levels of anxiety, deep depression, excessive delusions, or hallucinations), he or she may become confused, but his or her overall

intellectual *capacity* remains the same. This is true of anyone experiencing symptoms that affect health or emotional state. For example, when a person has the flu, he or she will not be at his or her best and may not seem to be very intelligent. People with mental illness, like people with other types of illnesses, achieve advanced degrees and become professionals in many fields.

**Fiction:** People with mental illness cannot make decisions for themselves and must be cared for by the mental health system.

**Fact: People with mental illness are capable of making their own decisions, and they have a right to do so.** In the early days of the mental health field, service providers assumed a parental, caretaking role, treating people with mental illness as helpless. Some theorists suggest that people with mental illness learned to be helpless from service providers who did everything for them. Considering that early treatments, such as high doses of Thorazine or high dose electro-convulsive shock therapy, were extremely sedating, it is understandable that people with mental illness might have acted "helpless." The current understanding of mental illnesses as biological, psychological, and social disorders has led to different approaches to treatment. It is now clear that people with mental illness are able to make their own decisions and that they have a right to do so, as long as those decisions do not compromise the rights and safety of other people.

***The current understanding of mental illnesses …has led to different approaches to treatment. It is now clear that people with mental illness are able to make their own decisions and that they have a right to do so, as long as those decisions do not compromise the rights and safety of other people.***

**Fiction:** Mental illness is a life long disease with no hope for a cure.

**Fact: Recovery is possible for people with mental illnesses.** People with mental illness are not all the same.

- there are many different kinds of mental illness and numerous diagnoses
- severity of symptoms is different in each person and different over time
- symptoms will affect each person's functioning differently
- symptoms of mental illness can be controlled through medication *and many other approaches*

Mental health service providers must consider the specific needs of each person and offer assistance in helping individuals to develop and implement a personal recovery plan.

Fiction: People with mental illness, particularly those involved in the criminal justice system, are resistant to treatment and difficult to engage in services.

Fact: **The task of engaging people with mental illness in services is the responsibility of mental health and other professionals.** People with mental illness involved in the criminal justice system may have different or more complex needs than other people with mental illness. It is the challenge for *professionals* to determine why the approaches they use with other individuals are not effective with this population. A good place to start is to *ask* the individuals targeted for service.

## Working Your Way Through the Criminal Justice System

This section applies a brief case scenario that follows a fictional person with mental illness through the criminal justice system.

### Complaint / Arrest / Booking

*Mr. Williams is a man of small stature, his appearance is clean but unshaven, and he has several boxes with him, some containing leaflets. One day he is found sitting on the church steps, blocking the front door. He verbally threatens anyone that attempts to enter the church. He shouts at passers-by, quoting religious scripture and tossing them leaflets. It is unclear to onlookers if he is demonstrating without a permit, or if his thinking is confused due to mental illness. The church deacon makes a complaint, which brings local police to the scene to investigate.*

*When the two police officers arrive, they approach Mr. Williams, asking him to identify himself and to clarify what he is doing on the church steps. Mr. Williams turns away and responds with a tirade consisting of an unintelligible jumble of words. He follows this with verbal abuse, first calling the officers names like "Lucifer" and "Satan," then adding some obscene names. He refuses to respond to their questions. The officers make it clear they are losing patience and insist that Mr. Williams leave the church steps. Mr. Williams then makes rude remarks about one officer's race and the other officer's appearance. The officers' annoyance begins to escalate. They approach him stating that he is under arrest. As they approach, Mr. Williams backs away, retreating into a corner. He drops to his knees, covers his head with his hands, and begins crying. He demands in an angry voice to be left alone. He says, "I am warning you, if you evil creatures continue to pursue the devil's work, there will be retribution!" One officer responds angrily, "Sir, are you threatening a police officer?" As they attempt to forcibly restrain him, Mr. Williams begins to scream and flail his arms, striking one of the police officers.*

**Crisis Intervention Teams (CIT).** In communities with police Crisis Intervention Teams, local law enforcement officers are able to recognize symptoms of mental illness and respond appropriately to people experiencing these symptoms. These officers are skilled at de-escalating crisis situations using verbal defusing skills and calming behaviors. For example, the Memphis CIT program provides training that includes information about mental illness and opportunities to develop crisis intervention skills (Reuland, 2004). An aspect of the program many find interesting and informative is the opportunity for dialogue with people with mental illness who have been involved with the criminal justice system. This dialogue helps the officers to understand the struggles of living with mental illness, to learn that people can recover from mental illness, and to hear the perspective of the person about whom a complaint has been made.

The CIT approach and other models of specialized police-based responses to people with mental illness rely on a cooperative partnership with mental health providers in the community. It is essential that police have ready access to mental health resources day or night and that the local mental health system provides a single point of entry (that is, one place for all mental health referrals), a "no refusal" policy at police drop-off points, and a streamlined intake service for police. Additionally, access to services is necessary for indi-

viduals who are in crisis, but who do not meet the criteria for emergency services (Reuland, 2004).

These kinds of cooperative relationships can help to avoid involving people with mental illness in the criminal justice system and facilitate access to mental health services.

*Mr. Williams is arrested. He is found to be in possession of marijuana and an unmarked vial of pills. He is taken to a crowded holding cell where he continues to shout and threaten; other inmates back away. Within 24 hours, Mr. Williams is taken to a local court for an initial appearance. The judge explains that he is charged with criminal trespass, resisting arrest, and assaulting a police officer. Bail is set and an attorney is assigned.*

## Pre-booking Diversion or Pretrial Release

During the initial appearance, rather than simply set or deny bail, the judge may release a defendant on his or her own recognizance and impose conditions of release. Pretrial services or jail diversion programs can identify individuals who may require mental health services and who might be eligible for pretrial release. The purpose is to identify individuals who become involved with the justice system due to mental illnesses and to divert them from the justice system to the mental health treatment system. Pretrial services can provide information and pose options to the court to assist in the pretrial decision and the possible setting of conditions of release. If conditions are imposed, pretrial services or jail diversion program staff may monitor the individual. If Mr. Williams were released, he would be required to comply with any conditions imposed by the court and to return to court for all scheduled court dates. If he failed to do so, the judge would issue a bench warrant for his arrest. Several jurisdictions have successfully used pretrial release for persons with mental illness (Clark, 2004).

The symptoms of mental illness often result in confused thinking. The person with mental illness may not understand the charges, and most people with mental illness are not able to post even very low bail.

### Detention Until Case Disposition

*Mr. Williams is then held in the local jail, where he continues to shout obscenities at the guards, refuses to cooperate, and often retreats into a corner. Again, his comments and behavior indicate to the guards that he is either frightened or furious.*

Upon entering jail, screening services should identify persons with serious mental health needs, including people at risk for suicide (Rold, 2003). With effective screening procedures in place, people with mental health service needs—such as Mr. Williams—could be identified early (Morris et al., 1997).

If an individual with mental illness is not identified through screening, he or she must either request services or come to the attention of corrections officers. If the corrections officers are trained to identify symptoms of mental illness, the person may then be referred to jail health or mental health services. Without training, corrections officers often don't understand that a person's unusual or disruptive behavior and difficulty comprehending directions, rules, or consequences may be due to mental illness and accompanying difficulty processing information.

If Mr. Williams had already been involved in mental health treatment locally, it could be very helpful for the jail mental health services to be in contact with Mr. Williams's community mental health providers. In many cases, jail services do not have information about a person's previous mental health treatment. As a result, medications prescribed at the jail may be different from medication the individual ordinarily takes or inappropriate for the individual. If the medication is different, the person may be faced with physical and emotional adjustments that usually occur with medication changes and which, in turn, may result in problematic behavior. If the medication is not appropriate, the person's symptoms will not be helped.

Exchange of information between community-based mental health providers and jail mental health services are regulated by local, state, and Federal law. It is important to examine the requirements in a given jurisdiction. The Federal Health Insurance Portability and Accountability Act (HIPAA) makes some exceptions for the exchange of information with correctional facilities or law enforcement. It also has provisions to accommodate the continuing care of a person from one mental health treatment setting to another. However, local or state regulations may be stricter than HIPAA requirements.

Jails and community mental health providers can establish coordinating committees to review or develop policies and procedures that facilitate communication. For example, the committee might explore the possibility of using liaisons between the jail and community mental health services or develop a standardized release form that meet all Federal, state, and local regulations.

## Case Disposition

*It is possible that charges will be dropped if Mr. Williams successfully meets conditions of pretrial release or diversion. Otherwise, Mr. Williams's case probably will be resolved in one of the following ways.*

### ▪ deferred prosecution

*Since Mr. William's crimes are minor and he has no criminal history, he may be offered deferred prosecution. This is more likely to happen if there is a formal pretrial intervention or pretrial diversion program in place. The offer for mental health program participation would generally have been made within a few days of Mr. Williams's arrest. If he agrees to the offer, his charges will be deferred. If he fails to complete the requirements, criminal proceedings will be reinstated. If Mr. Williams successfully completes the agreed upon requirements, charges may be dismissed or reduced.*

In some jurisdictions, the prosecutor may offer defendants the opportunity to have charges dropped or reduced if the person agrees to participate in a treatment or diversion program. (In some jurisdictions, deferred prosecution requires court approval; in others the prosecutor has full authority.) This agreement specifies duration of participation and program requirements. There is generally supervision by staff of the diversion program, probation department, or other community corrections program, with required communication between service providers and the court (sometimes directly with the judge) (Clark, 2004).

***Release of Information***

To fulfill Federal and state statutory mandates, a release of information must clearly specify the

- person receiving services
- program or person releasing the information
- person/persons or agency to whom information will be released
- kinds of information to be released
- purpose for providing the information
- length of time for which the permission will be valid

### ▪ sentence to jail time and re-entry

*If Mr. Williams pleads guilty or is found guilty after trial and sentenced to jail, it is likely that at some point his mental illness symptoms will need attention. If Mr. Williams was involved with mental health services and prescribed medication prior to his arrest, ideally he should continue to receive the same medication, unless there is some significant reason to change that medication.*

*Mr. Williams will also need services upon release. He will need housing, benefits, treatment, and case management services. While incarcerated, Mr. Williams's benefits may be suspended or terminated. (See page 12.) Upon release, it will be necessary for benefit providers to be contacted if his benefits are to be reinstated. Housing programs for people with mental illness may be reluctant to accept people released from jail, especially if they have been convicted of any offense that involves aggressive or violent behavior or substance abuse. Ideally, Mr. Williams will have a jail discharge plan.*

Discharge planning may involve initiating case management services prior to a person's release, so that housing, entitlements, and treatment services are in place. With services and benefits in place, the person is more likely to avoid re-arrest (Steadman & Morrissey, 2002). In some jurisdictions, a case manager is assigned to the jail (Osher et al., 2002).

A problem that arises for case managers or other discharge planners is the unanticipated release of a person. The discharge planner may be in the middle of accessing entitlements and services for an individual, only to find out that the person went to court and never returned to the jail because the judge released him or her for time served. Cooperative relationships between discharge planners and the courts can help to resolve these problems. (Discharge planners in prison settings also face the problem of not being notified about changes in release dates.)

Even with a comprehensive discharge plan and services in place, the problem often arises that the person is reluctant to be involved in treatment. "Reach in" services by consumer-run programs have been instituted in some jails and prisons to educate persons in jail about how to use the mental health system. These services require the cooperation and support of the correctional facility. One such program is operated by Hands Across Long Island, Inc. (HALI), a multi-service agency managed by and for people whose lives have been changed by mental illness. HALI's Consumers with Conviction Program works with inmates at Sing Sing and Riverhead prisons. (McCormick, 2005)

## ▪ sentence with mandated treatment

*Mr. Williams's sentence may involve probation and participation in an alternative to incarceration, diversion, or other type of community corrections program with conditions requiring treatment participation.*

In this type of disposition, the probation department (or other community corrections program) and treatment providers should consider how they will work together to:

- communicate about compliance with treatment mandates — mechanisms and frequency
- decide upon special or specific conditions that relate to mental health treatment programming
- develop appropriate sanctions for behaviors that violate service program rules or conditions of probation (such as graduated sanctions)
- identify other areas where community corrections and treatment providers can partner in the interest of supporting the individual's recovery

*If Mr. Williams is sentenced to probation, and the mental illness has not been identified throughout the course of this case, Mr. William's symptoms may make it difficult for him to fulfill his probation obligations.*

With training, probation officers and other community correction program staff can better identify persons experiencing symptoms of mental illness. These individuals should be referred for evaluation and treatment. Probation departments and other community corrections programs, such as alternative to incarceration (ATI) programs, often complain that it is difficult to obtain appointments for mental health evaluations or that continued communication with mental health providers is problematic. Mental health agencies often complain that probation and ATI staff are either not sensitive to the struggles of managing symptoms of mental illness and that consequences for not following mandates are too harsh, or that persons with mental illness are given too much leniency and are not held sufficiently accountable by probation or ATI staff. Many communities address these problems through criminal justice/mental health coordinating committees, cross training, interagency agreements, and dedicated case loads. (See Consider the Benefits of Partnerships, page 33.)

***Individuals with Serious Mental Illness May Have Difficulty Following Through on Evaluation Appointments***

Criminal justice providers often become frustrated in their attempts to refer individuals with mental illness for evaluation, treatment, or other services. It's important to keep in mind that mental illness can interfere with focus, concentration, and memory. For example, a probation officer gives directions (date, time, and location) about an appointment and writes the information on a slip of paper. The person may never hear or understand these instructions or fail to follow through because symptoms interfere. The person may be

- hearing voices and having difficulty paying attention
- overwhelmed with anxiety about the appointment
- experiencing paranoia and not trust enough to follow through
- extremely depressed and not fall asleep until 4 am, then sleeping through the appointment time
- oversleeping due to the sedative side effects of medication
- unable to plan how to get to the location (the person may not have funds for public transportation, may not know how to access transportation, may not know how to use public transportation)
- too confused by symptoms to navigate a public transportation system

Partnerships with community mental health providers can help to meet these challenges through developing effective procedures for making referrals and assisting individuals to keep appointments (Massaro, 2005). Case management can play an essential role in this process.

# The Basics of the Mental Health Service System

This section provides clarification for criminal justice professionals about:

- who can or should receive services in the mental health service system,
- who provides the services, and
- how services are paid for.

## Who Is Served?

Public mental health services for a wide range of mental health problems are available to individuals, couples, and families. These services are for people from all socioeconomic backgrounds and cultures and include persons involved with the criminal justice system. Mental health services are provided for mild to severe problems with anxiety, depression, or substance abuse; for problems in family functioning, situational crises, or children with adjustment or conduct problems; and for problems of serious mental illness. People with serious mental illness may experience episodic or prolonged impairment in functioning. Impairment may include difficulties in self-care, social activities, and activities of daily living and problems in concentration and performance of cognitive tasks. Depending upon the severity of illness, these individuals require treatment and rehabilitation as well as support services such as financial support, housing, and healthcare.

Generally, local mental health programs provide services to individuals involved with the criminal justice system, accepting referrals for evaluation and

treatment from county probation departments, state parole services, pretrial services, and diversion programs.

## Who Provides the Services?

In each state, mental health services are overseen by some branch of state government. This may be an office or department of mental health, which may be under the auspices of a department of health or human services. (Some states combine mental health services with services for persons with substance use disorders; others include services for persons with mental retardation and developmental disabilities.) States vary in the degree of direct involvement with actual mental health service delivery. Most commonly, services are regulated at the state level but administered at the county level. These services may be provided directly by the county or the county may contract with a private company for services.

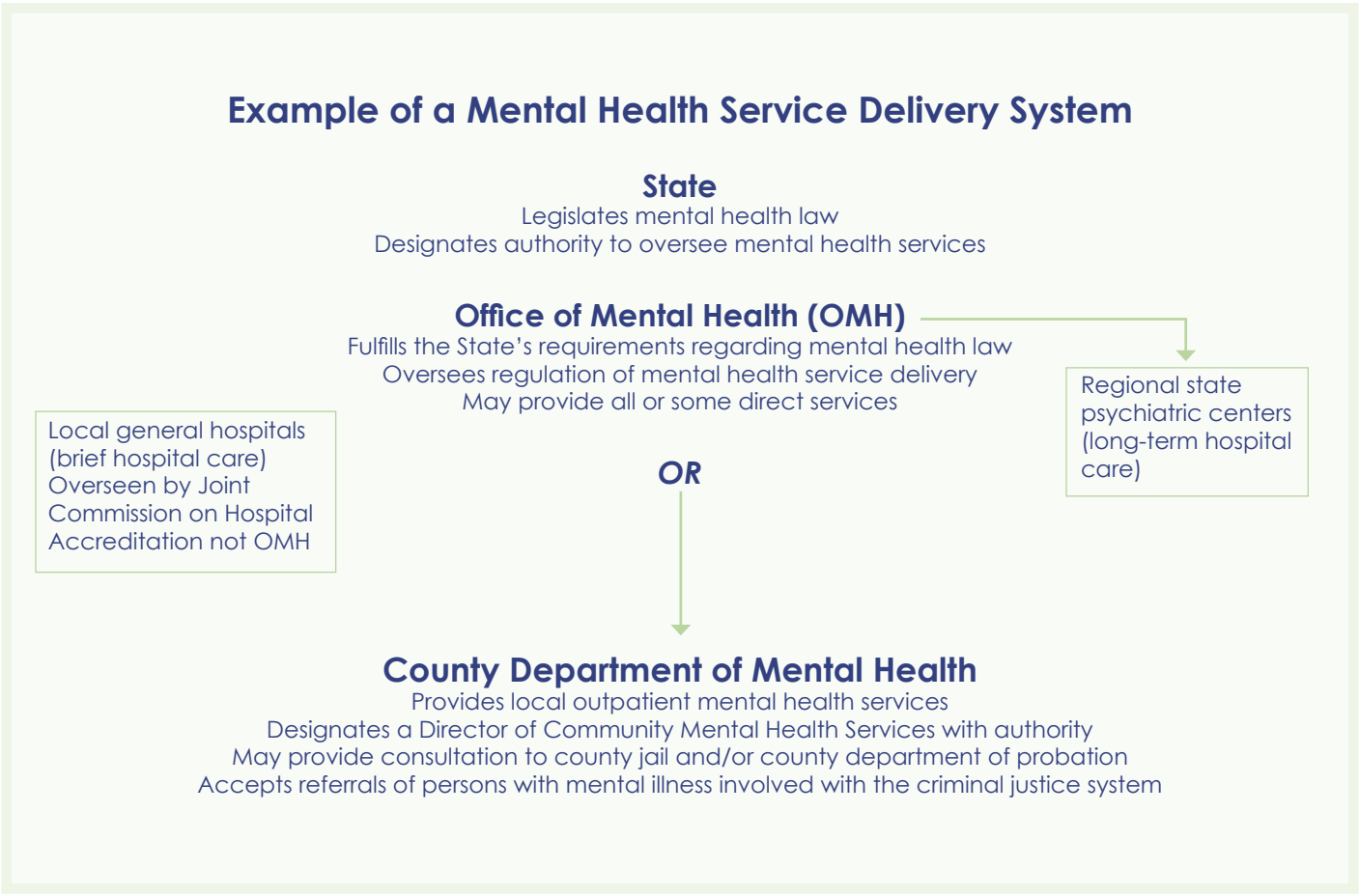
In some states, services are provided directly at the state level or through some combination of state and local services. For example, the state may operate regionally located psychiatric hospitals, but allocate responsibility for community-based services to the county.

Mental health services may be provided to jail inmates directly by county mental health services and to state prison inmates either directly by the state's department of corrections or through agreements with state mental health departments. Alternatively, mental health services to jails, prisons, probation departments, or state parole services may be provided by private or not-for-profit mental health agencies through contracts with these criminal justice services or with local mental health departments.

## How Are Services Funded?

**Public sector mental health services are paid for through a variety of sources, including Federal, state, and local funds.** Each state receives a small percentage of its budget for mental health services through the Federal Mental Health Block Grant (a separate block grant provides funding for substance abuse treatment services); these funds are supplemented through state general revenues, with additional funding often provided at the county or local level. In most states, funds are allocated to and administered at the county level (National Association of State Mental Health Program Directors, 2005).

***People with serious mental illness may experience episodic or prolonged impairment … Depending upon the severity of illness, these individuals require treatment and rehabilitation as well as support services such as financial support, housing, and healthcare.***




Some types of services for persons with mental illness may be funded through other Federal programs administered at the state level. For example, some types of housing are funded through the Department of Housing and Urban Development (HUD), and some types of vocational services are funded through the Department of Education.

**The majority of funding for mental health services comes from Medicaid and Medicare.** Medicaid is a joint state and Federal government program. Medicaid pays for medical and mental health services for individuals who meet income, resource, age, disability, or other requirements and who cannot pay for all of their medical care. Within Federal guidelines, each state administers its own program and establishes its own eligibility standards. Each state determines the type, amount, duration, and scope of services and sets the rate of payment for these services. Most people eligible for Temporary Assistance for Needy Families (TANF), through the Department of Health and Human Services, or Supplemental Security Income (SSI), through the Social Security Administration, are eligible for Medicaid assistance (Centers for Medicare & Medicaid Services, 2005). Each state establishes its own procedures for Medicaid application. Medicaid does not pay for all necessary mental health services; it excludes inpatient hospital mental health care and some types of rehabilitative services. Medicaid disability requirements are generally the same as those for SSI.

**Medicare is a Federal health insurance program, administered by the Social Security Administration.** This program is available for people 65 years of age and older, some people with disabilities under age 65, and people with end-stage renal disease. If the person receives Medicare, it will pay for mental health services; however, many restrictions apply (Centers for Medicare & Medicaid Services, 2005).

**The Social Security Administration does not directly pay for mental health services.** Social Security makes available two programs that provide an important source of income for people with disabilities, including those disabled by mental illness. These are Supplemental Security Income (SSI), for persons with low income who are disabled, elderly (over 65), or blind, and Social Security Disability Insurance (SSDI), for people who are disabled but who have worked and paid Social Security taxes. Depending on their work history, individuals may qualify for both SSI and SSDI. *Persons receiving SSI generally are eligible for Medicaid; recipients of SSDI usually qualify for Medicare after 24 months.* Financial assistance through these programs is *only* available to individuals who *apply* and *qualify as having a disability* as defined by strict Federal guidelines (Social Security Administration, 2001, 2002). Disability determinations can be difficult to obtain, even for those with serious mental illness. Bureaucratic "red tape" aside, one issue is the length of time a person has experienced symptoms, and another is the degree to which the mental illness causes disability. A person whose mental illness has been identified and treated early may not meet requirements for disability. This person may still need assistance, however, and without it may become disabled.

**Jail and prison time can affect benefits.** While many individuals with serious mental illness in jails and prisons are eligible for benefits, few return to the community enrolled in benefit programs. This limits their access to the medication and services that are essential to successful re-entry to the community. Having Medicaid upon release is associated with greater use of services and decreased arrests (Steadman & Morrissey, 2002).

Medicaid law does not allow state medicaid agencies to use Federal matching funds to pay for services provided to persons in jail or prison. However, Federal law does not require that Medicaid benefits be *terminated* upon incarceration. The Centers for Medicare & Medicaid Services encourages states to *suspend* rather than terminate benefits when an individual is incarcerated. Suspension allows for easier reactivation of benefits upon release and thereby increases access to the medication and other needed mental health services (Centers for Medicare & Medicaid Services, 2005).

SSI benefits also can be affected by incarceration, depending upon the length of time the person is in jail. The Social Security Administration may suspend payments if the person is incarcerated for less than 12 consecutive months. These benefits

***The Centers for Medicare & Medicaid Services encourages states to suspend rather than terminate benefits when an individual is incarcerated.***

***Federal Benefits and Incarceration***

The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments (CSG), is a national effort to assist policymakers, criminal justice professionals, and mental health professionals to improve responses to people with mental illness who become involved (or who are at risk of involvement) with the criminal justice system. The Consensus Project and the CSG Re-entry Policy Council are working to understand the Federal benefit rules, to help states to streamline their processes, and to facilitate the coordination of research efforts in this area. (For further information visit www.consensusproject.org and www.reentrypolicy.org)

will resume soon after the person leaves jail *if the Social Security Administration is notified* that the person has been released and if the person submits a form with evidence indicating that he or she continues to meet the financial requirements. Social Security presumes the person continues to be disabled. Individuals incarcerated for more than one year must reapply for benefits and must demonstrate both financial need and continued disability. Assistance from correctional facilities and mental health services can help restore social security benefits to persons with mental illness returning to the community from prison. Note that most states will terminate Medicaid eligibility if SSI benefits have been suspended.

## Public Mental Health Services

The criminal justice and mental health systems intersect at many points. It is important for professionals in each system to have some knowledge of the other system's components and purposes. Four primary categories of public mental health services are described here:

- emergency services
- hospital services
- community-based services, and
- support services.

Public mental health services generally include both treatment and support services. Each of the two broad categories is subdivided according to the severity of the mental health problem and the intensity of service required. During a crisis, emergency and hospital services may be necessary. Other mental health services are be provided at clinics, rehabilitation centers, or other community-based programs, and they are supplemented through support services such as housing, case management, and peer programs. A given community may have several agencies or agency components that provide these services. Ideally, a full continuum of services operates as a well-coordinated, continuous system of care.

Mental health providers often find it challenging to engage individuals involved with the criminal justice system in mental health services. When people refuse treatment, mental health service providers are constrained by state-specific statutory requirements regarding involuntary hospitalization (commitment) when the person is in danger of harming self or others. (See Hospital Treatment — Inpatient, page 17.)

## Mental Health Emergency Services

Although most people with mental illness are not violent, when a person is experiencing a mental health crisis or emergency in the community, the nature of the person's behavior may warrant the involvement of law enforcement officers. Similarly, if a person experiences a mental health emergency while incarcerated, corrections officers and jail/prison health or mental health services must intervene. During a mental health crisis, it may be necessary for law enforcement or corrections officers to escort an individual to designated emergency/crisis services for evaluation.

Emergency mental health services, often called "crisis services," provide intervention for individuals experiencing acute episodes of mental illness (an episode

***Dangerous?***

Public perception about the link between mental illness and violence is often skewed by sensationalized reporting in the media, popular misuse of terms such as psychotic and psychopathic, and exploitation of narrow stereotypes by the entertainment industry.

The results of several large-scale research projects conclude that only a weak association between mental disorder and violence exists people with mental illness living in the community. Violence by people with mental illness appears to be concentrated in a small subgroup of individuals, especially those who use alcohol and other drugs. The way to reduce even this modest association between mental illness and violence is to increase accessibility to a wide range of mental health services and to eliminate the stigma and discrimination associated with mental illness (MacArthur Foundation Research Network on Mental Health and the Law, 2004).

of dramatic increase in symptoms). Communities vary in their approaches to crisis services, developing responses that meet their unique needs. Crisis services often are located in a general hospital emergency room, a psychiatric hospital, or a specialized crisis response site, such as a crisis triage center or crisis stabilization unit (Steadman et al., 2001). Services are provided by medical doctors, psychiatrists, and other mental health professionals. Some services provide alternatives for crisis intervention that are not hospital based. These services help to resolve many mental health crises so hospitalization is not necessary. They also assist people in accessing outpatient or community-based services. These types of services play an essential role because psychiatric hospitalization usually is limited to individuals who are at most serious risk.

Law enforcement officers generally become involved in mental health crisis situations in one of two ways. Sometimes there is a complaint that requires investigation. When police respond and determine that the person may be experiencing a psychiatric problem, they may take the person to a crisis service for evaluation. Law enforcement officers generally are authorized in their actions by relevant statutes, codes, or policies (Steadman et al., 2001). Another circumstance may involve a treatment provider requesting transportation of a person already involved in treatment for crisis evaluation. In this type of situation, the police can only fulfill this request if given proper authorization. State mental health law will specify who can provide this authorization. In most states, authorization can come from a psychiatrist, a director of community services, or a mental health professional (e.g., social worker, psychologist, or psychiatric nurse) designated by the director of community services.

When police become involved in a mental health crisis, they often find themselves in the frustrating situation of spending long periods of time accompanying persons with mental illness in the emergency room. It is even more frustrating if the person is not admitted to the hospital because he or she does not meet criteria for emergency treatment. A variety of approaches are evolving to help remedy these problems. Mobile crisis units are utilized by some communities, with the advantage of delivering a team of mental health professionals *to* the person, *at* the crisis situation or at specified satellite locations in the community. However, these services have limited capacity to manage persons who are intoxicated or violent.

Some communities make use of specialized crisis response sites, such as crisis triage centers or crisis stabilization units, to improve interactions between law enforcement and emergency mental health services. A key aspect of such sites is a "no-refusal" policy for law enforcement officers, which allows them to drop off persons in crisis and return to regular patrol duties (Reuland, 2004). It gives law enforcement a single point of access to mental health services and disposition of crisis situations. Another critical element for success of these programs has been cross-training of police officers and mental health providers in order

to enhance collaboration (Steadman et al., 2001). These specialized crisis response sites are an important element of police-based, pre-booking mental health jail diversion programs, which help to produce a mental health disposition of a situation in lieu of arrest and detention. Police-based approaches to pre-booking diversion include Crisis Intervention Teams (CIT) as well as models in which law enforcement officers and mental health professionals co-respond to situations involving people with mental illness.

The emergency or crisis service will evaluate the individual's psychiatric need and *will determine the least restrictive service setting that is appropriate for the person at the time.* The crisis service may be able to help the person resolve the crisis, so that a referral to community-based services can meet the person's needs. When individuals in crisis do not meet criteria for hospitalization but do require a less-restrictive mental health service, they should be both referred *and* linked to those services through case management or other approaches. Unfortunately, not all hospitals or crisis programs provide 24-hour case management services, and many people leave without proper follow-up.

***Police-Based Crisis Intervention Teams (CIT)***

Police-based models of crisis intervention have some advantages over a mental health-based mobile crisis team. The model is also a good fit for many law enforcement services.

- Police are the only crisis responders able to reach the scene in 10–15 minutes
- Police are always available, 24/7
- Police must always be available in unsafe situations
- Police has more options in regard to safe transport of individuals to mental health services
- CIT officers have specialized skills, but retain other patrol responsibilities

(Steadman et al., 2001; Reuland, 2004)

Decisions about hospital admission also may be affected by other issues. For example, if the hospital decides it does not have adequate services to treat an individual (due to alcohol intoxication, drug use, or a known history of violence), it may refuse to admit that person. On the other hand, empty beds are costly to hospitals, so when beds are plentiful, admission criteria may be more flexible as long as the services are guaranteed financially.

If it is determined the person does meet the requirements, *and* the person voluntarily accepts treatment, the person will be admitted to a hospital. If he or she is unwilling to accept treatment, an assessment of dangerousness to self or others must be made. That is, there must be a legal determination of whether involuntary commitment is necessary.

**Involuntary inpatient psychiatric commitment** is a legal process that can require an individual to accept or participate in inpatient psychiatric treatment. It typically applies to individuals deemed to be a danger to self or others. This legal proceeding is generally covered under state mental health law and administered through local civil courts. The definition of "dangerous" and the process through which a person can be deemed dangerous varies between jurisdictions. The definition can be limited to obvious and immediate risk of violence toward self or others or, more broadly, include the inability to care for self or, based on historical patterns, the likelihood of future decompensation (escalation of symptoms) and dangerousness. Most states require certification by one or more psychiatrists. More recently, many states have applied the concept of psychiatric commitment to requirements for participation in *outpatient* treatment for some individuals; however, the criteria and associated services of outpatient commitment are very different than for inpatient commitment. (Note: All states have due process requirements for notice and a hearing to review civil commitments.)

***Accessing Mental Health Services Through Emergency or Crisis Services – Problems Often Encountered By Law Enforcement and Jail Personnel***

When a person is in a psychiatric crisis, it is often the perception of criminal justice providers (and perhaps community mental health providers as well) that the individual is in need of hospitalization. However, in order to be hospitalized, the person must:

- need services beyond the scope of those available in an outpatient or community-based service
- be willing to accept hospitalization or
- meet criteria for involuntary commitment

If the person does not meet these criteria, he or she will be referred to services in the community.

## Hospital Treatment — Inpatient

When people with mental illness are admitted to the hospital, the length of stay may be very brief. Criminal justice professionals may wonder why these individuals are discharged so quickly.

Mental health services should be provided in the least restrictive environment. Many of the services once provided only in hospitals can now be accessed in expanded community-based mental health service systems. This limits psychiatric hospitalization to only those individuals with severe mental health needs, those who cannot care for themselves or whose mental health symptoms present a danger to themselves or others. This may include people with severe situational crises that lead to suicidal thoughts and behaviors or those with serious symptoms of mental illness. However, the fact that someone is experiencing serious symptoms of mental illness (sometimes referred to as decompensation) does not necessarily mean that hospital inpatient services are necessary.

When hospital services are deemed necessary, services are targeted to stabilize the person as quickly as possible and return him or her to the community with the appropriate community treatment and support services in place. Individuals who require short-term hospital stays are usually treated in a general hospital or private psychiatric hospital. Individuals that require longer hospital stays are generally treated in state-operated psychiatric hospitals.

Hospital inpatient services provide:

- acute stabilization—medication and other services to rapidly reduce the severity of symptoms
- intensive treatment during periods of acute illness
- 24-hour supervision in a safe and controlled environment
- complete care to enable the person to recover from the acute episode
- intensive rehabilitation (individual, group, and family treatment and educational services)

When the person is hospitalized, the length of stay may be brief. Ideally, the length of stay is determined by the severity of the illness and the type of hospital/inpatient setting. However, factors unrelated to the person's mental health condition, such as hospital policy, the nature of the person's benefits, insurance reimbursement or other financial factors, may also affect length of stay. Once again, the availability of beds may become a factor. People are likely to be discharged earlier if the hospital is overcrowded and may be allowed longer stays if beds are available and payment for services is guaranteed.

When people are released from a hospital, they are usually referred for continued mental health treatment, as described below. However, even when people leave the hospital with an appointment at a community-based service, they may not follow through. One study found that 36 percent of people missed their first appointments at a mental health clinic. The study identified a variety of factors as contributing to missed appointments, including not being able to pay for the service and cultural factors (Kruse et al., 2002).

***Out of the hospital already??***

Psychiatric hospitalization is available only to persons with *severe* mental health needs – those who cannot care for themselves or whose mental health symptoms make them a danger to themselves or others. These are people who either voluntarily accept treatment or who are involuntarily committed to the hospital.

Most hospital stays are meant *only* to stabilize the person. Hospital services are intended to reduce symptoms sufficiently so the person can be treated in the community. The challenge for community mental health providers is to engage and keep the person involved in treatment. When mental health providers are not successful with engagement, the person's behavior may re-involve law enforcement officers.

## Community-Based Mental Health Treatment Services

Criminal justice professionals come in contact with community-based mental health services for a variety of reasons, but most often it is to obtain a mental health evaluation for an individual or to obtain confirmation that an individual is fulfilling treatment mandates established by the court, diversion program, probation department, parole division, or others. Since mental health problems vary greatly in the nature and severity of symptoms, people with mental health problems require a wide variety and range of services. This section briefly describes the kinds of community-based treatment settings.

Community-based mental health treatment services are provided to individuals and families with a wide range of mental health service needs. These non-residential services are sometimes referred to as "outpatient" services. Services may be centrally located or dispersed throughout the community. Counseling and other treatment services are tailored to the severity of mental health problems or the person's stage of recovery.

### Clinics

Mental health clinics provide counseling services for individuals, couples, and families experiencing a range of mental health problems. They also provide more intensive services for people with psychiatric disabilities. These services include diagnosis, treatment plans, and medication services to help reduce disabling symptoms and facilitate wellness and recovery. Mental health clinics are staffed by professional counselors, social workers, psychiatric nurses, psychologists, and psychiatrists. Professionals are assisted by other individuals with varying degrees of training such as mental health therapy aides.

The types of treatment services provided at mental health clinics or outpatient mental health programs include:

- Assessment — gathering information to determine the person's treatment needs
- Diagnosis — determining the nature of the mental health problem
- Treatment planning — a plan made with the individual receiving services as to the kinds of services to be received
- Counseling/Talk therapy — helping people change through gaining insight and understanding, building self-esteem, developing coping abilities, or other strategies
- Medication therapy, medication education, and medication management — prescribing medication and providing patients with an understanding of medication actions, side effects, and how to manage their medications
- Health screening services for those receiving medication
- Symptom management — teaching people ways to help manage their symptoms
- Psychiatric rehabilitation readiness — preparing people for activities that help them to embark upon the changes necessary for recovery

- Family support services — educational and supportive programs for families of persons with serious mental illness

These services are often supplemented by a variety of community support services.

### Day Treatment

Day treatment programs (sometimes called "continuing treatment" or "continuing day treatment") keep individuals involved in therapeutic activities during the course of the day or part of the day. Day treatment provides the structure that helps to maintain the person in community living. Therapeutic activities are designed to maintain or enhance levels of functioning and skills in order to promote recovery and wellness. Day treatment programs may supplement clinic programs or incorporate typical clinic services.

### Partial Hospitalization

Partial hospital programs provide the same services as inpatient settings, with the distinction that the person returns home during parts of the day (for example, in the evenings to sleep). Partial hospital programs provide an alternative to inpatient hospitalization or reduce the length of hospital stay within a medically supervised program. They are designed to provide active treatment to stabilize and reduce acute symptoms.

### Psychiatric Rehabilitation

Psychiatric rehabilitation is provided in community-based programs that assist persons with serious mental illness to overcome challenges created by aspects of the illness that interfere with functioning and cause disability. They help the person to expand abilities of self-care, employment, recreation, or social relationships. These programs also help the person to create or strengthen a network of people and activities that can provide the support necessary for wellness and recovery. Psychiatric rehabilitation services, like all mental health services, should place an emphasis on partnering with the individual in planning and pursuit of recovery.

Psychiatric rehabilitation services may include:

- preparation — for activities that help to embark upon the changes necessary for recovery
- setting goals — selecting specific environments for living, working, learning, or socializing
- assessment of abilities and resources — developing an understanding of the person's ability and skills and the potential resources he or she has in the community to meet goals
- skills and resource development — improving the person's skills and arranging for or adapting social and environmental resources necessary to achieve rehabilitation goals
- vocational or educational services — referral to services that prepare the person for increased independence and possible employment

These services are often supplemented with community support services.

### Assertive Community Treatment (ACT)

ACT is a team-based service delivery approach that focuses on engaging individuals at high risk for hospitalization or homelessness. It provides intensive treatment and support through 24-hour service availability; outreach services; and delivery of comprehensive services, including mental health treatment, substance abuse/addiction treatment, transportation, peer support, and access to vocational services, benefits, and other community supports. ACT teams provide comprehensive, continuous, and coordinated

#### *Forensic Assertive Community Treatment (FACT)*

Jail diversion programs that provide FACT have the potential to optimize success, preventing the re-arrest and incarceration of persons with mental illness (Lamberti et al., 2004).

mental health services to optimize successful engagement.

An emerging practice has been the application of ACT teams to working with persons with mental illness involved with the criminal justice system. These forensic assertive community treatment (FACT) programs partner with criminal justice agencies and place a greater emphasis on substance abuse treatment and supervised residential components. FACT programs differ from other assertive community treatment programs in the prioritization of persons involved with the criminal justice system, the predominance of criminal justice agencies as referral sources, and the integration of mental health and criminal justice agency services (Lamberti et al., 2004).

## Support Services

An array of services is available to support recovery from mental health problems. These support services should not be confused with treatment services provided in clinical settings. Case management support services can provide the necessary link between the criminal justice system and the mental health system. They help to maintain communication and connect people to the concrete services that enable them to pursue recovery and fulfill their obligations to the criminal justice system.

***Coordination and Communication***

Some communities, constrained by small populations and limited resources, may combine mental health services under the umbrella of one agency.

Larger communities may have numerous public and not-for-profit programs delivering these services. When a person receives services from a number of agencies, coordination of care becomes essential. Usually a "primary therapist" and/or a "primary case manager" assume responsibility for maintaining communication among all mental health service providers. They are also responsible for communication with other service providers and, if signed releases are obtained, with the criminal justice system.

Support services assist persons with serious mental illness to live in the community, and they play an essential role in the process of recovery. These services can include case management, housing and housing supports, peer programs, and self-help and mutual support, among many others.

### Case Management

Case management links people to services in an effort to create a comprehensive continuum of care.

***Peer Programs***

Peer programs are mental health service programs administered and staffed by individuals in recovery. The special skills of "peer specialists," lie in their unique ability to connect with their peers – other individuals with psychiatric diagnoses. A wide range of mental health services are provided by these programs, including outreach, advocacy, case management, social programs, psychiatric rehabilitation, vocational and employment services, and counseling.

Forensic peer specialists are individuals in recovery from mental illness (and often from co-occurring substance use disorders) who have a history of incarceration or other involvement with the criminal justice system. Forensic peer specialists have demonstrated the capacity to engage their peers in services when other mental health service providers have been unable to do so. They are important members of ACT or FACT teams. These forensic peer specialists can play a key role in helping others avoid relapse and recidivism. Traditional mental health services also employ social workers, psychologists, nurses, and other professionals in recovery.

***Communication and Confidentiality***

Federal, state, and local statutes dictate guidelines in relation to communication and confidentiality. *These laws are meant to protect the individual's privacy, not to impede communication essential to providing services and treatment.* The Federal Health Insurance Portability and Accountability Act (HIPAA) plays a significant role in protecting the privacy of a person's health care information. Mental health service providers, including hospitals, are entities covered by HIPAA. In addition, state and local laws may impose standards that go beyond Federal requirements. HIPAA requires mental health agencies and service providers to obtain permission from the person with mental illness to communicate with other service providers. The person gives permission by signing a release of information form that complies with Federal, state, and local laws. Social service programs are regulated by different state agencies and have different requirements in regard to interagency communication about individuals receiving services. To simplify this issue, the agencies in a community can create common information release forms; however, these must meet the strictest level of Federal, state, or local requirements. Agencies may also develop interagency agreements to facilitate communication. (See Explore or Expand Partnerships, page 34.)

There are some circumstances in which HIPAA does not apply to the exchange of information with correctional facilities or law enforcement (although state or local regulations may be stricter than those of HIPAA). The National Council on Correctional Health Care has developed standards for accredited facilities that are detailed in the publication, *Standards for Health Services in Jails* (2003). The American Public Health Association also has developed standards on the confidentiality of medical records in correctional facilities. There are circumstances, too, where a court can order an agency to provide information about a specific individual, for example, when a person refuses to sign a release of information or rescinds permission (Skeem & Petrila, 2004). A criminal justice and mental health task force can be formed in the jurisdiction to investigate applicable Federal, state, and local regulations. This can lead to formal agreements governing the exchange of information.

Cross-training helps providers to understand these and other special issues in relation to communication, such as requirements that mental health professionals report child abuse and neglect or requirements that law enforcement officers not disclose information related to ongoing investigations. Cross-training can enhance mutual respect and appreciation. It can also uncover "unofficial" obstacles to communication that reside in staff attitudes, beliefs, and behaviors.

Case management programs bring the service to the person or the person to the service. The objective is to provide the greatest flexibility in helping people to achieve independence and meet personal goals.

Case management services are provided by both public and private agencies. Many case management programs are sponsored by consumer advocacy, peer-run programs (programs administered and staffed by individuals in recovery. (See Peer Programs text box, page 20.) Experience and education requirements for mental health case managers vary, but many have bachelor or master degrees in social work. Case management services can be targeted to people of either gender, of any age, and with any diagnosis or issue. Services also can be targeted to the severity of illness and the extent of need.

The primary task of case management programs is the coordination of services with various agencies and service providers. Case managers may be the primary liaison between providers of different service systems, and often between the mental health service system and the criminal justice system. For example, a case manager can provide a liaison between an individual's probation program and mental health treatment program. The case manager can facilitate ongoing follow-up, regular contact, and communication within

the boundaries of Federal, state, and local confidentiality requirements.

Case management matches a person's individual needs to available services. Typical needs include housing, financial supports, treatment (therapy and medication), rehabilitation, medical assistance, education or training necessary for employment or meaningful activity, and support with legal issues. The ability to match the person to the most appropriate service will, of course, be limited by the availability of services in the community.

Case managers may provide hands-on assistance with all aspects of daily life, but the specific activities with an individual will be dictated by the treatment plan. They can help people with basic daily living skills (such as shopping or time management) and help them to manage the details of treatment and rehabilitation, such as making and keeping appointments. Case managers also provide a great deal of guidance, encouragement, and emotional support through informal counseling, which not only builds resilience but reinforces pursuit of individual recovery goals. Case management as a discipline operates under the principle of empowerment. That is, case managers try to empower people with mental illness to make their own decisions and take charge of their lives. Case managers are not caretakers, parental figures, or enforcement officers. They help people to develop and/or utilize the skills necessary to fulfill their own obligations and take responsibility for their own behavior.

***Levels of Support***

Case management programs are often structured according to the amount of support required by the individuals served and the stage of their recovery. Specific guidelines may dictate the frequency of contact and the availability of support. For example, persons at high risk for relapse and who respond best to frequent contact may be assigned to an *intensive case management* program where they see a case manager at least once a week and there is 24-hour, daily on-call availability; individuals who are more stable but who need some continued support may require the services of a *supportive case management* program, where they meet with the case manager less frequently (perhaps twice per month); and those who only need periodic assistance may be enrolled in *community support services*.

***Some Types of Housing Programs***

**Apartment Programs** - Apartment living is meant for individuals who have achieved sufficient recovery to perform a full range of self-care skills (such as budgeting, taking medications independently, shopping, and cooking). Apartment programs may provide transitional housing or permanent housing, and they are supported by various levels of service depending upon the needs of the individual. People who continue to need intensive support services may receive rehabilitative services and regular visits from case managers that can lead to greater independence. Others may have already achieved independence and require minimal support.

**Service-Enriched Single Room Occupancy Residences** - These are private rooms or studio apartments meant for extended stays for persons with limited self-care and socialization skills. Individuals may receive some on-site supportive services, case management, and rehabilitative services.

**Community Residential Programs** - Community residences are a form of congregate treatment. These programs are for people with severe symptoms of mental illness who can greatly benefit from 24-hour supervision but who do not require hospital services. These residences provide supervision and services that promote rehabilitation and recovery. They are intended as transitional housing, where people develop the capacity to live more independently.

### Housing and Housing Supports

Providers and people receiving services recognize that housing is essential in rehabilitation and recovery of persons with serious mental illness. Appropriate housing is highly correlated with pursuit of independent community living. One study shows that providing housing for persons with mental illness who are homeless reduces criminal justice involvement by 38 percent for jail days and 84 percent for prison days (Culhane et al., 2002). This study also reveals reductions in shelter use, hospitalizations, and length of stay for hospitalizations.

Housing services may include a residential treatment service (community residential programs) or simply housing with various levels of support (supported housing). Departments of mental health may directly fund, license, or oversee certain housing services for persons with mental illness. Housing may also be provided through other Federal and state agencies with support provided through mental health services. People with mental illness often receive help in accessing housing services through case management programs, peer advocacy programs, or programs for people who are homeless. However, some mental health housing programs can only take people who have SSI/SSDI, creating a problem for those who have not yet qualified. (See Medicaid, page 12.) It can be difficult to find housing that is both affordable and located in a safe area of the community.

### Peer Programs and Services

Peer programs are administered and staffed by individuals in recovery. These are people with mental health or substance use problems who provide services for others with the same types of problems. Peer programs can be very effective in engaging people in services who have previously been reluctant to engage in them, particularly individuals with co-occurring mental illness and substance use disorders involved with the criminal justice system. These individuals often report they can relate better to their peers than to other professionals. Peer programs also provide a critical source of support by creating opportunities for associating with others who have had similar experiences (Solomon, 2004). Developing and maintaining a network of supports can be essential to recovery from both mental illness and substance use disorders.

Some examples of peer-operated mental health services:

- Drop-in centers — places to find support without an appointment

***Peer programs can be very effective in engaging people in services who have previously been reluctant to engage in them, particularly individuals with co-occurring mental illness and substance use disorders involved with the criminal justice system.***

- Social clubs — places for recreation and socialization with others in recovery from mental illness
- Self-help and mutual support programs — programs initiated and operated by individuals seeking support from others struggling with the same life issues — in this case, recovery from mental illness and substance use disorders
- Advocacy services — offer assistance in gaining access to various services, obtaining benefits, negotiating legal problems, or meeting other basic needs
- Educational programs — classes that help people to understand their mental illnesses, how to cope, how to care for themselves, and many other survival skills
- Activities of daily living assistance — provides help in developing or enhancing the skills of every day life necessary for independence
- Employment or vocational programs — programs to prepare people for employment; employment is an important source of self-esteem and fosters self-reliance in recovery
- Housing — some housing programs are peer operated; other housing programs use peer counselors to provide a variety of supports
- Case management — some case management programs are peer operated; others use peer counselors as case managers

People in recovery may have professional degrees and work in any of the mental health services described in this monograph. Many peer specialists and forensic peer specialists also fill counseling and case management positions.

## Self Help and Mutual Support

Criminal justice and other service providers often misunderstand the role of self-help programs. These programs do not provide treatment, but they do provide essential support to individuals during treatment and help them in their pursuit of recovery.

Self-help services provide information through literature, the Internet, the media, or other sources for people to help themselves with a given life problem. Many organizations provide mutual support through meetings and other contacts. These organizations comprise individuals who provide support to one another in coping with a particular type of symptom or social problem. Usually anyone can attend a group meeting, and no one is turned away.

By the nature of these programs, seeking help is supposed to be an individual and voluntary decision; however, attendance often is mandated or strongly advised by treatment programs or criminal justice agencies. Most self-help/mutual-support programs are run independently of treatment agencies; however, treatment programs also may run support groups.

Self-help/mutual-support associations and meetings can be found in every community for many types of symptoms or problems. Meetings can be found in public agencies or in community centers such as schools, churches, libraries, and public meeting halls. Self-help programs include the many "12-step" programs such as Double Trouble, for people with mental illness and co-occurring substance use disorders; Alcoholics Anonymous (AA), for people with alcohol abuse problems); Narcotics Anonymous (NA), for people with problems of drug abuse and addiction; and Alanon, for relatives and friends of persons with mental illness or addiction problems. These programs sometimes offer sponsors — people who volunteer to provide support and guidance to other individuals at earlier stages of recovery. Many self-help/mutual-support programs have both "open" (those open to the public) and "closed" meetings (limited to select individuals). Criminal justice and mental health professionals are encouraged to attend open meetings so that they might make better referrals or better understand the role of these programs in the recovery process.

For many years, the only approach to self-help was the Alcoholics Anonymous 12-step approach, but now many other approaches have evolved to meet the needs of those for whom the 12-step approach is not successful. No one approach has proven more

successful than another. A diversity of programs provides more opportunities to engage individuals in the self-help process in support of their recovery. Unfortunately, in many places there is not much variety in available self-help programs. Most programs that provide support to individuals with substance use disorders do not exclude individuals with co-occurring mental illness.

Some of the many self-help programs:

- 12-step — AA, NA, or Alanon
- Double Trouble or Double Trouble Recovery — a 12-step program that focuses on co-occurring mental illness and substance use disorders
- Support Together for Emotional/Mental Serenity and Sobriety (STEMSS) — a *supported* self-help (or mutual help) model for recovery from co-occurring mental illness and substance use disorders—it makes some use of mental health professionals
- SOS, Secular Organizations for Sobriety (or Save Our Selves) — a mutual support program for persons with substance use disorders who are uncomfortable with the spiritual content of 12-step programs
- Women for Sobriety — both an organization and a self-help program for women who are alcoholic, based on the idea of empowerment and positive affirmations
- Women Helping Other Women — a self-help program for women struggling with many life issues, including mental illness, substance abuse, or trauma from physical or sexual abuse

Support programs can also include drop-in centers and social clubs. These are informal settings where people have an opportunity to socialize. There are no requirements for attendance and people come and go as they like.

***Attend Your Self-Help Meeting?***

Community corrections programs and the courts not only mandate people with mental illness and co-occurring substance use disorders to receive treatment, they often mandate them to attend self-help groups such as Alcoholics Anonymous (AA) for problems of alcohol abuse and addiction; Narcotics Anonymous (NA) for problems of drug abuse and addiction; Double-Trouble for co-occurring disorders; or social clubs. Since these organizations are voluntary, anonymous, leaderless, and confidential, there is no official way for an individual to prove his or her attendance.

# Mental Health System Components in Operation

## The Case of Ms. Kent

This case scenario, featuring a fictional individual, demonstrates how mental health system components operate in relation to one another and interface with the criminal justice system.

*The police received a complaint of someone behaving dangerously on a bridge. When police arrived, a young woman, approximately 20 years old, was traversing a six inch wide railing of a bridge, laughing and talking rapidly to no one in particular. The young woman identified herself as Kelsey Kent, daughter of Clark Kent, but she refused to come down. As police were trying to coax her to safety, she kept explaining that she could not be harmed, that she was protected by anti-kryptonite that she had in her pocket. The police pulled her to safety, only to be punched, scratched, and bitten as she attempted to escape.*

*The law enforcement officers could not be sure if the young woman was under the influence of drugs or if she was experiencing symptoms of mental illness. Since the behavior seemed potentially suicidal, they chose to take her to the local hospital emergency room for a mental health crisis evaluation.*

**Emergency Crisis Services.** *At the emergency room, the officers were required to remain with the young woman until her evaluation has been completed. After an hour, the attending physician and consulting psychiatrist decided to admit her to the hospital's psychiatric ward. At this point, the officers finally could leave the emergency room. Ms. Kent surprisingly agreed to be admitted to the hospital.*

Some hospitals will not admit an individual who appears to be under the influence of drugs or one who has behaved violently, because they do not have the capacity to manage such individuals.

Of course, it would be extremely helpful for the hospital staff to know if Ms. Kent has had previous mental health services in the community. A hospital or other agency providing emergency psychiatric services can enter into an associate's agreement with local treatment providers. This is an interagency agreement between separate mental health service agencies to facilitate communication without compromising Federal HIPAA requirements. The associate's agreement can allow the emergency service to receive updated lists of active clients and expedite medical record information to assist in evaluation (Costa, 2003).

**Hospital Treatment.** *Ms. Kent was then transferred from the emergency room to the hospital psychiatric ward, accompanied by information regarding the need for admission. Her diagnosis was deferred at admission until a drug test could be done.*[1] *Although the drug screen was positive for marijuana, the young woman's high energy, rapid speech, and delusional thinking were not in keeping with symptoms of marijuana intoxication. (Delusions are a disturbance in perception that leads to false beliefs; experienced as powerfully real to the individual, but not held by others). Ms. Kent was later diagnosed as having a manic episode of bipolar disorder. She was administered medication (prescribed by the psychiatrist and administered by the nursing staff); she also received psychotherapy (talk therapy) by a psychologist. As the medications began to take effect, Ms. Kent's symptoms of mania subsided, only to be followed by symptoms of depression. After a few days, the social worker began to develop a discharge plan coordinated with the local mental health clinic. Confidentiality laws required the social worker to obtain a signed release form from Ms. Kent to make these arrangements.*[2] *Although Ms. Kent's symptoms were still pronounced, it was determined she could be treated effectively in the community. Ms. Kent's discharge depended upon whether she was a danger to self or others, medications have begun to take effect, and symptoms have begun to subside (that is, she is "stabilized").*[3]

At the time of the referral, the hospital discharge planner will be in communication with the clinic and will send agreed upon diagnostic and treatment information. If Ms. Kent had previously attended the mental health clinic, communication should begin at the time of admission, with the hospital requesting information from the clinic (again with Ms. Kent's permission).

Once discharged from the hospital, Ms. Kent will be involved with many of the following services simultaneously.

**Clinic Services.** *Local mental health clinics (sometimes referred to as mental health centers) are often the hub for access to a full range of services. At the local mental health clinic, Ms. Kent is assigned a primary therapist. She will be evaluated and diagnosed again by the clinic psychiatrist.*

---

1. The effects of many street drugs and some prescription can drugs mimic or mask symptoms of mental illness. When there is suspicion of drug use, it is best to defer diagnosis until drug effects and withdrawal effects have subsided.

2. It may be possible for the local mental health clinic and hospital to establish a formal agreement to expedite exchange of information and facilitate discharge planning.

3. Many other factors may affect how long a person is in the hospital. Availability of beds and assurance of payment for services likely will play a part. An issue rarely discussed is the nature of interactions between staff and patients. If Ms. Kent is disrespectful, rude, lies, steals, rejects the help offered, and is generally disruptive of the hospital ward, staff may choose to discharge her at the earliest opportunity.

*Depending upon her behavior and how she has responded to medication and treatment, the diagnosis may change. A comprehensive treatment and support plan will then be developed with Ms. Kent, which reflects her preferences. Clinic services will be available for continued medication evaluations, psychotherapy and family counseling. The treatment plan will indicate how often Ms. Kent will be seen at the clinic for counseling and what professionals will be involved in her treatment. Her diagnosis and medications will be reviewed by a psychiatric nurse and a psychiatrist periodically, usually at least every 90 days. The primary therapist should remain in regular contact with any adjunct services such as day treatment, partial hospital programs, and case management services regarding Ms. Kent's overall functioning. In this case, Ms. Kent will likely be encouraged to participate in educational programs (sometimes called psychoeducation), to help her to understand the nature of her mental illness. She will also need to learn about the possible effects of using alcohol or other drugs on her mental health.*

Various components of the criminal justice and mental health systems may recognize that an individual needs treatment for both mental illness and substance use disorder. The two disorders are ideally treated simultaneously within the same treatment service. People will fall along the full length of a continuum of symptoms of each disorder—people may have mild substance use disorders but severe mental illness, or severe substance use disorders but mild mental illness. Providers often have difficulty serving all of these individuals within the same program. Another complicating factor is that funding and regulations for the treatment of mental illness and substance abuse often come from two different sources. While the availability of integrated treatment services for persons with co-occurring mental illness and substance use disorders has been increasing steadily over the past several years, in many communities the services available for persons with co-occurring mental illness and substance use disorders are insufficient or inadequate to meet the needs (Drake et al., 2001; Watkins et al., 2001).

**Case Management Services.** *Ms. Kent will be assigned a case manager (often a professional social worker). The case manager will help her to access financial supports (often referred to as benefits or entitlements, which may include TANF, food stamps, SSI/SSDI, Medicaid, Medicare), housing, and other social services. The case manager also will coordinate the service plan, remaining in close contact with all service providers. If Ms. Kent has any obligations to a court, diversion program, probation department, or other community correctional program, the case manager may facilitate transportation to appointments or communication between agencies.*

***While the availability of integrated treatment services for persons with co-occurring mental illness and substance use disorders has been increasing steadily over the past several years, in many communities the services available for persons with co-occurring mental illness and substance use disorders are insufficient or inadequate to meet the needs (Drake et al., 2001; Watkins et al., 2001).***

Young people with bipolar disorder (and some other mental illnesses) often will have extensive involvement with the criminal justice system. They frequently are unaware they have mental illness and use alcohol and street drugs to self-medicate their symptoms. The behaviors associated with the illness often appear more "deviant" than "disordered." Training of police officers, probation officers, and other community corrections or program staff, may help to identify many more young people with mental illness who have become involved with the criminal justice system.

**Housing.** *Upon release from the hospital, Ms. Kent will probably continue to need a substantial amount of support, so her housing services should accommodate these needs. Immediately following a crisis, many individuals need housing which provides 24-hour supervision. The type of housing and support services is matched to the person's level of functioning.*

Many communities have very limited available and affordable housing for persons with mental illness (NAMI, 2004; O'Hara & Miller, 2001). Housing providers sometimes have concerns or limitations in serving persons, such as the young woman in this scenario, who need monitoring or assistance because they are impulsive, aggressive, seek constant attention (often through negative behaviors); are in frequent conflicts with other residents; or abuse alcohol and other drugs. The behaviors of a few individuals can affect the willingness of housing providers to work with individuals involved in the criminal justice system.

**Partial Hospital Services or Day Treatment.** *Depending upon Ms. Kent's level of functioning, she also may be assigned to a partial hospital or day treatment program for active therapeutic involvement during the course of the day.*

Day treatment programs often must serve individuals at many different levels of functioning, so it can be difficult to meet individual needs, particularly in communities with very limited resources for mental health services.

**Psychiatric Rehabilitation.** *As Ms. Kent continues to improve, she may be transitioned from day treatment into a rehabilitation program. This type of program helps to further build on social and other skills necessary for independence.*

It is important to remember that recovery is possible for people with mental illness. The recent development of more effective medications, more comprehensive services, and involvement of clients in treatment planning can help people with mental illness to be successful, contributing members of their communities. Psychiatric rehabilitation can be an important component of treatment that facilitates the recovery process.

**Additional Supports.** *Ms. Kent also may decide to make use of a peer support program, self-help program, social club, or employment readiness program. She may also make use of peer advocacy services.*

Peer support can be very helpful in engaging individuals with mental illness in treatment, especially those with criminal justice involvement. Mental health and criminal justice professionals can support the use of peer specialists by hiring individuals in recovery and contracting with peer programs.

# Mental Health Service Delivery

## Modalities of Treatment

Programs providing treatment for mental illness, substance abuse, or co-occurring disorders utilize a variety of treatment methods. *Treatment modality* is the term commonly used to describe these general methods. The treatment modality often refers to *who* is included in a treatment session along with the therapist or counselor, such as:

- individual therapy — just one person
- group therapy — a number of individuals with some common issues or problems

- family treatment — generally includes various members of a family or individuals living together
- couples therapy — generally refers to two people in a primary relationship such as a marriage

The modality may also refer to the kinds of services received such as:

- medication therapy — where medication is prescribed and medication management is taught
- psychotherapy — where individuals talk to a therapist in order to develop insight, change behavior, or solve life problems
- psychoeducation — where people learn about mental illness symptoms and symptom management

## Treatment Providers

It can be confusing for service providers outside of the mental health system to understand *who* provides treatment services and the differences between these providers. Treatment services are provided by professionals with various educational backgrounds, who may be simply referred to simply as "clinicians." Some services may also be provided by nonprofessionals.

**Medical services.** Many mental health treatment services must be overseen by a healthcare professional, particularly if medication is being administered. Each of these professionals *might* also provide psychotherapy ("talk therapy").

Psychiatrist — A psychiatrist is a physician who evaluates people with mental illness, makes diagnoses, and prescribes medication for psychiatric disorders. Some psychiatrists provide psychotherapy, but in a clinic setting, most do not. A psychiatrist may also be responsible for reviewing and approving the overall treatment plan. Some psychiatrists specialize in mental health legal issues (forensic psychiatrist) and will make evaluations as to legal competency or provide expertise regarding determinations of individuals pleading not guilty by reason of mental disease or defect.

Psychiatric Nurse — A psychiatric nurse is usually a registered nurse (RN), an individual with a four year degree in nursing, who specializes in psychiatry. A psychiatric nurse's responsibilities will vary by the mental health treatment setting and may include: administering medication, dispensing medication, overseeing medical evaluations, and medication management.

Physician's Assistant (PA) — A physician's assistant is has many of the same responsibilities as a physician, but has a more limited education. In some states, the PA must be supervised by a medical doctor or psychiatrist, but in other states, the PA has his or her own licensing. A PA can prescribe medication.

Nurse Practitioner (NP) — Much like a physician's assistant; the specifics of responsibilities and privileges vary with each state. A nurse practitioner can prescribe medication.

Psychologist — Individuals with either a master's degree (MA) or a doctoral degree (PsyD or PhD) in psychology can identify themselves as a "psychologist." In a treatment setting, there is virtually no difference between the PsyD and PhD. Some psychologists specialize in psychological testing at either the master's level or doctoral level. Depending upon local regulations, doctoral level psychologists may also determine a diagnosis and approve treatment plans. (A master's degree is often required for school psychologists, who generally provide psychological testing and counseling in school settings.) Each of these professionals might also provide psychotherapy.

Social Worker — Social workers provide a variety of social services. Professional social workers have a bachelor's or master's degree from an accredited school of social work. A master's degree in social work is generally a three-year degree with a supervised internship or practicum. Social workers are licensed in many states. Social workers in the field of mental health provide psychotherapy, case management, and other supportive services.

Counselor — Anyone that provides guidance and support can be identified as a counselor. Some individuals will have a master's degree in counseling or

rehabilitation counseling. Treatment programs often hire individuals in recovery from substance abuse or mental illness as counselors. For example, an "addictions counselor" may be a person in recovery from addiction and "peer counselor" frequently refers to counselors in recovery from mental illness. States may require some counseling positions to have specified levels of training and certification.

Other Counselor Titles:

- residence counselor — provides supportive services in housing or residential programs
- drug abuse counselor, addictions counselor, substance abuse counselor, alcoholism counselor — provides substance abuse counseling services
- MICA (Mental Illness and Chemical Abuse) counselor — provides counseling to individuals with co-occurring mental illness and chemical abuse problems
- therapy aide, psychiatric counselor — non-professional mental health workers
- peer specialist, peer counselor — counselor in recovery from mental illness
- forensic peer specialist — counselor in recovery from mental illness who works with individuals involved with the criminal justice system

Note that sometimes a job title is "counselor," but it does not necessarily reflect the person's educational level, which may be a bachelor's or master's degree in counseling, rehabilitation, social work, psychology, or nursing.

Case Manager — These are individuals who provide guidance, support, and linkages to services. Educational requirements vary widely, but often case managers must have a bachelor's or master's degree in social work or equivalent field. Some case management programs are staffed by peer specialists. (See Case Management, page 20.)

## Practices That Reflect Quality Care in Mental Health Services

Some individuals with mental illness who become involved in the criminal justice system are reluctant to engage in treatment and services, yet it is clear that recovery is possible. People with the most serious mental health problems can achieve recovery with very high levels of functioning, becoming successful, contributing members of the community.

People with mental illness involved with the criminal justice system often have very understandable reasons to avoid mental health services. Some feel coerced into participating in treatment activities they do not want and feel forced to take medication with powerful side effects. Some do not feel respected by mental health professionals and fear losing control over their own lives. Others have cultural beliefs and customs that may be poorly understood by many mental health providers. Previous abuse and trauma at the hands of people in authority can create powerful obstacles to the trust necessary for treatment. These or many other issues may be the source of a given person's reluctance to become involved with mental health services. *The challenge is for professionals* to find ways to engage people with mental illness involved in the criminal justice system in treatment and other services and to foster personal responsibility for recovery.

The course of recovery depends upon many factors, including the severity of mental health disorders, individual responses to treatment (medication and other therapies), and the resources available to the individual to develop a network of support — both family and community supports. Recovery also is dependent upon the availability and quality of a wide range of services to provide a comprehensive, continuous system of care.

These services include:

- housing

- clinic services for medication and medication management
- programming for treatment and rehabilitation, including treatment for co-occurring substance use disorders
- financial assistance through entitlements
- case management
- peer supports and self-help programs
- medical services and supports for physical health and well-being

These services should be consumer focused, individualized, and oriented to recovery.

## Best Practices

Providing quality mental health services involves the application of practices with proven efficacy. The following are practices for which there is consistent scientific evidence that demonstrates improved outcomes. The mental health system refers to these as *evidence-based practices* (SAMHSA, 2005).

**Illness self-management.** Recovery can be supported by encouraging and assisting people to take charge of their own mental health and well-being. Illness self-management (many people prefer the terminology, *wellness* self-management) teaches each person to understand his or her mental illness. It helps individuals to identify and utilize those elements of treatment and rehabilitation he or she has found to be most effective. The individual's own recovery plan, sometimes referred to as a "personal recovery plan," may include medication, psychotherapy, self-help programs, peer support services, careful nutrition, exercise programs, alternative therapies, or other approaches the person finds useful.

**Medication management approaches.** While the use of medication is one part of an overall mental health treatment plan, medication can be a vital recovery tool. Best practice encourages the use of medications with proven efficacy, which should be accompanied by proper medication management skills to increase independence in managing medications (SAMHSA, 2005).

***People with mental illness involved with the criminal justice system often have very understandable reasons to avoid mental health services.***

**Family psychoeducation.** Families of people with mental illness often have spent many years feeling confused, guilty, hurt, angry, and discouraged. They may not understand the person, the mental illness, or how to help. Many try to distance themselves from the family member with mental illness. Family psychoeducation services are educational programs for families to learn about mental illness, how to respond to people experiencing symptoms, and how to support recovery. These programs have demonstrated improved outcomes for people with mental illness and their families.

**Assertive Community Treatment (ACT).** Assertive Community Treatment is a service delivery approach that uses a team of professionals, available on a 24-hour basis, to deliver comprehensive and coordinated intensive treatment and support services. These services often target individuals at high risk for homelessness, hospitalization, or other institutionalization. Some communities utilize ACT for persons with mental illness involved with the criminal justice system. (See ACT, page 19.)

**Supported employment.** Depending upon the severity of illness, people with serious mental illness usually require some financial support through a variety of benefits. As they achieve recovery, they become capable of employment. Employment is a crucial source of self-esteem in our culture, and people with mental illness desire employment, just as others do. Supported employment is a service that helps people with mental illness find and keep competitive employment. Agencies work with employers and consumers to provide the necessary supports to enable people to face the challenges of employment without compromising their recovery.

**Integrated treatment for co-occurring mental illness and substance use disorders.** Many people with mental illness involved with the criminal justice system also have co-occurring substance use disorders. Both the mental illness and the substance use disorder should be treated *simultaneously* and in one setting. In many places, both may be treated at the same time or sequentially, but by two different service systems. The recommended approach is to consider the interactive effects of both disorders and to integrate treatment. This particular practice is one of the most essential in providing services to people with mental illness involved in the criminal justice system. In order to establish integrated treatment, the other best practices must be incorporated.

***Social Security Disability Benefits and Paid Employment?***

The Social Security Administration allows persons on disability to participate in paid employment without losing SSDI/SSI. There are caps on the amount of money people can earn.

**Summary.** It is important to note that while each of these "best practices" alone has demonstrated consistent effectiveness, it is anticipated that the best outcomes will be achieved when these services are provided in combination.

## Quality Services

The quality of mental health services can be enhanced further with attention to cultural competence, the problems of trauma histories, and the utilization of peer programs.

**Cultural Competence.** Cultural factors, including race and ethnicity, frequently contribute to differential access to services and disparities in service provision (US Surgeon General, 2001). Cultural factors also include language, socioeconomic status, religion, gender identity, and geographic location. Racial and ethnic disparities are evident in the criminal justice system as well. Throughout the nation, blacks and Hispanics are over-represented in the criminal justice system, including state and Federal prisons, jails, probation, and parole (Harrison & Beck, 2004; Harrison & Karberg, 2004; Glaze & Palla, 2004).

The mental health system attempts to address these disparities by encouraging the development of cultural competence in service delivery. Whenever possible, a cultural match should be made between workers and service recipients. Recipients also should be provided

with an opportunity to communicate in their first language. Cultural competence involves knowledge of the culture of recipients and awareness of the influences of one's own culture, for example, how it can influence attitudes, beliefs, and behavior. Cultural competence is the provision of effective and respectful service compatible with the cultural beliefs, practices and languages of people receiving services; it assures effective mental health treatment and services across cultures (Office of Minority Health, 2000).

**Trauma.** Men and women with mental illness, as well as those with co-occurring substance use disorders and those involved with the criminal justice system, experience very high rates of physical and sexual abuse as children and as adults (Alexander, 1996; Goodman et al., 2001; Teplin et al., 1996; Veysey, 1997). This abuse often results in "trauma," a form of psychological shock that results in both emotional and physical symptoms. The constellations of symptoms that people experience as a result of trauma are referred to in the mental health field as "post incident stress" or "posttraumatic stress" disorders. The effects of trauma can complicate other mental illness or substance use disorders, and the symptoms of trauma frequently trigger relapse (a return or increase in other symptoms of mental illness or a return to drug or alcohol use).

A number of treatment approaches specifically address the effects of trauma and how they interfere with recovery. Some approaches provide information about the effects of trauma on recovery and teach people strategies to resist these effects. Other approaches explore the traumatic events and their impact on the individual in more depth. In working with individuals involved with the criminal justice system, mental health and substance abuse treatment services should be responsive to the impact of trauma (Moses et al., 2003).

**Peer advocacy and peer support.** People in recovery who have a history of mental illness, substance use disorders, and criminal justice involvement can play a powerful role in engaging their peers in treatment and assisting them in the process of recovery. Their intimate understanding of the problems encountered make them ideal advocates for accessing treatment services, benefits, and assistance with legal problems. Self-help and peer support services have demonstrated the capacity to enhance the effectiveness of other services (Magura et al., 2002). Utilizing programs administered and staffed by peer specialists can bridge some of the gaps that emerge in serving this population. (See Peer Programs and Services, page 24.)

**Summary.** The implementation of these practices will help to ensure quality services, dramatically improving the lives of many people with mental illness and making recovery a reality.

# What Can Criminal Justice Professionals Do?

## Consider the Benefits of Partnerships

The criminal justice system can benefit from partnerships with the mental health service system.

**Law enforcement.** Partnerships formed between law enforcement agencies and mental health programs to resolve issues surrounding intervention in mental health emergencies can result in the

- reduction in injury to police officers and to persons requiring intervention
- reduction in the amount of valuable law enforcement time required for accompanying persons with mental illness while they are evaluated for treatment admission
- elimination of duplicate services
- elimination of working at cross purposes

**The courts.** When judges, prosecutors, defense attorneys, and others in the court system partner with the mental health system to establish and utilize diversion programs, there can be benefits to the criminal justice system and to people with mental illness. Diversion programs can help to:

- reduce jail overcrowding and allocate limited space for individuals with more serious charges
- reduce burgeoning court dockets
- avoid burdening local jails with the costs of providing expensive medication and treatment
- connect people with mental illness with the necessary treatment and services

**Jails and prisons.** Jails are as different as the communities that they serve, and prisons vary greatly from state to state. However, each is required by the Constitution to maintain the health and well-being of inmates. Large city jails and prisons may have full in-house mental health services, while small county jails may have only intermittent consultation with mental health providers. The benefits of partnerships will vary accordingly. In many cases, partnerships between jails or prisons and the mental health system can help to facilitate:

- evaluation and treatment of persons with mental illness
- continuity of care for persons diagnosed previous to incarceration
- required discharge/release planning
- safety of suicidal individuals

**Community corrections.** Correctional services provided in the community may involve parole (community supervision after leaving a state correctional facility), county probation, ATI programs, or other community correction or diversion programs. Partnerships with the mental health service system may increase the success of community corrections while reducing the incidence of violations and recidivism. Partnerships can help to:

- establish mechanisms for effective and speedy referrals for evaluation
- facilitate communication — by clarifying the nature of information to be disclosed, mechanisms for communication and the local, state, and Federal laws regarding confidentiality; establishing interagency information release forms
- identify those persons at greatest risk who require the most immediate and comprehensive services
- develop joint practices that support recovery and successful completion of obligations

(Massaro, 2005)

## Explore or Expand Mechanisms That Support Partnerships

Many communities have found the following mechanisms to be useful in establishing and maintaining partnerships.

**Memoranda of Understanding (MOU) or Interagency Agreements.** Memoranda of understanding are formal agreements between public service agencies that can facilitate service delivery through cooperative efforts (Massaro et al., 2002; Center for Mental Health Services, 1995; Steadman et al., 1995). For example in New York State, the Office of Mental Health developed a cooperative relationship with the Division of Parole and established a MOU that enhanced coordination with regards to mental health evaluations for the Board of Parole, increased discharge planning for persons with serious mental illness receiving treatment from the Office of Mental Health in New York State prisons and being released back to the community, implemented mental health training for parole officers, and established intensive case management services for persons with serious mental illness on parole.

**Cross training.** Cross training is an opportunity to develop partnerships by bringing together criminal justice and mental health service providers to receive training on a topic of mutual interest. Cross-training provides a common base of knowledge and helps to build understanding and mutual respect between professionals.

**Coalitions.** Cooperative ventures between the local criminal justice and mental health systems can be strengthened through the establishment of a task force, coalition, coordinating committee, or interagency team. These committees and teams can monitor progress, identify problems, and investigate solutions (Peters & Hills, 1997; Cushman, 2002).

**Boundary spanners and liaisons.** Individuals who can work across systems to facilitate communication and coordinate policies or services are referred to as "boundary spanners." Liaisons are individuals who serve as the primary contact person for communication between agencies. For example, an ATI program may designate one staff member to communicate with the court. Often there are natural leaders in the community to fill this role (Steadman et al., 1995).

**Dedicated or specialized case loads.** A promising strategy for meeting the needs of persons with mental illness on probation, parole, or other community corrections program is the use of specialty or designated caseloads. This approach designates small groups of staff in community corrections and in mental health to work with individuals on shared caseloads. These caseloads generally are smaller, providing more intensive services from both mental health and community corrections (Peters & Hills, 1997). For example, in a rural New York county, one probation officer was assigned to supervise a case load of fourteen women with mental illness. An identified team of mental health staff worked with these women, and one staff member acted as a liaison to the probation department. In this community, an interagency agreement provided for regular meetings between the probation officer and mental health liaison to discuss the progress of their mutual clients. (This of course, required formal permission from service recipients in the form of specific, signed release forms.) This approach has been recommended by the Council of State Governments (2002) in its Criminal Justice/ Mental Health Consensus Project.

Probation officers with dedicated case loads often are more inclined to "problem solve" than sanction. Smaller case loads (under 40) allow these officers to make probation more rehabilitative than punitive (Skeem et al., 2003; Skeem & Petrila, 2004).

**Coordinated interagency crisis management**. When mental health providers and components of the criminal justice system develop coordinated plans to manage mental health and other crises, duplication of services and working at cross purposes can be eliminated.

**Joint efforts to establish conditions of behavior and consequences.** When community corrections and mental health agencies establish conditions of behavior and consequences together, sanctions with a therapeutic impact that can facilitate success in meeting community correction obligations can be achieved.

For additional information on these and other promising practices, contact the TAPA Center for Jail Diversion. (See page 39.)

## Advocate for Change

People with mental illness who have committed minor offenses do not belong in the criminal justice system. If they do become involved, it is important to divert them to community mental health services. Throughout this monograph, there have been references to strategies that have been explored by many jurisdictions. Some communities have had more success than others in implementing changes, but in each case, the successes have resulted in benefits for the entire community. The chances for success are likely to improve with cooperation between the mental health and criminal justice systems. Each community must examine its own strengths and weaknesses, identify the strategies with the most promise, and adapt strategies to the needs and unique circumstances of the community.

The impetus for change comes from many sources. Too often it comes through some tragic incident or misfortune. It may also come from a desire to consolidate resources. Or perhaps it will come from a desire to improve the quality of life for people with mental illness.

## Summary

With increasing numbers of people with mental illness becoming involved with the criminal justice system, it has become necessary for the criminal justice and mental health systems to expand their working relationships and develop partnerships. In order for partnerships to be effective, the professionals in each system must understand the other system—its purpose and responsibilities, its components, and how these components function. In addition, they must begin to understand the limits and challenges that exist in each system. Many jurisdictions must face the realities of limited resources. The two systems can work together to establish mutual goals, explore new approaches, or find the gaps in existing efforts that diminish success. Together, they can begin to pool the available resources, identify new funding opportunities, and find ways to make the best use of existing resources. Together the two systems can work to successfully divert people with mental illness with minor crimes from the justice system into treatment, and help those who have been sentenced to avoid recidivism and re-arrest.

## Works Cited and Works Consulted


Alexander, M. J. (1996). Women with co-occurring addictive and mental disorders: an emerging profile of vulnerability. *American Journal of Orthopsychiatry*, 66(1): 61-70.

Center for Mental Health Services. (1995). *Double Jeopardy: Persons With Mental Illnesses In The Criminal Justice System. A Report To Congress From The Center For Mental Health Services*. Rockville, MD: Author.

Centers for Medicare & Medicaid Services. (nd). *Medicaid: A Brief Summary*. Retrieved 2005 from www.cms.hhs.gov.

Centers for Medicare & Medicaid Services. (nd). *Medicare: A Brief Summary*. Retrieved 2005 from www.cms.hhs.gov.

Centers for Medicare & Medicaid Services. (2004). Letter from Glenn Stanton, Acting Director, Disabled and Elderly Health Programs Group on the subject of Ending Chronic Homelessness.

Clark, J. (2004). Non-Specialty *First Appearance court Models for Diverting Persons with Mental Illness: Alternatives to mental Health Courts.* Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion.

Costa, M. R. (2003). How to develop an integrated and effected corporate HIPAA compliance plan. (From the Sixth National HIPAA Summit, March 28, 2003). Retrieved from www.ehcca.com/presentation/hipaa6/4_03.pdf.

Council of State Governments. (2002). Criminal Justice/Mental Health Consensus Project. New York: Author.

Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reduction associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13(1).

Cushman, R. C. (2002). *Guidelines for Developing a Criminal Justice Coordinating Committee*. Washington, D. C.: U.S. Department of Justice, National Institute of Corrections, Accession Number 017232.

Deegan, P. E. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4).

Drake, R. E., Essock, S. M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services* (52)4.

Glaze, L. E., & Palla, S. (2004). *Probation And Parole In The United States, 2003*; NCJ 205336. Office of Justice Programs, U.S. Department of Justice, Bureau of Justice Statistics.

Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S.D., Swartz, M., Essock, S.M., et al. (2001). Recent victimization in women and men with severe mental illness: prevalence and correlates, *Journal of Traumatic Stress*, 14(4), 615-633.

Harrison, P., & Beck, A. (2004). *Prisoners 2003*. Bureau of Justice Statistics. U.S. Dept of Justice, Office of Justice Programs.

Harrison, P., & Karberg, J. C. (2004). *Prison And Jail Inmates At Midyear 2003*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Bulletin, NCJ 203947.

Imas, K. (2004). Federal benefits and re-entry: stopping the revolving door for people with mental illness released from prison. *The Council Of State Governments Eastern Regional Conference Monthly Issue Brief*, October 2004.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52:4.

Kruse, G. R., Rohland, B. M., & Wu, X. (2002). Factors associated with missed first appointments at psychiatric clinic. *Psychiatric Services*, 53(9).

Lamberti J. S., Weisman, R., & Faden, D. I., (2004). Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. *Psychiatric Services*, 55(11).

MacArthur Research Network on Mental Health and the Law. (2004). The MacArthur Violence Risk Assessment Study, May 2004 Update of the Executive Summary. Retrieved from http://macarthur.virginia.edu/risk.html.

Magura, S., Laudet, A. B., Mahmood, D., Rosenbloom, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services*, 53(3).

Massaro, J., McCormick, C. T., Rotter, M., Steinbacher, M., Marmo, R. C., Lurie, A., & Abreu, D. (2002). Transitions: *Providing Services to Persons Diagnosed with Mental Illness Returning to Their Communities From Prison.* Albany, NY: New York State Office of Mental Health.

Massaro, J. (2004). *Working With People With Mental Illness Involved In The Criminal Justice System; What Mental Health Service Providers Need To Know*, 2nd Edition. Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion.

Massaro, J. (in press). *CONNECT: Promoting Recovery for Persons with Serious Mental Illness and Co-Occurring Substance Abuse Disorders on Probation or in ATI Programs*. Albany, NY: New York State Office of Mental Health (to be published in 2005).

McCormick, C. T. (2005). Personal communication with Terry McCormick, recently with the New York State Office of Mental Health Division of Forensic Services and currently with CARES, LLC, identifying programs provided by Hands Across Long Island in the Suffolk County jail and in Sing Sing Correctional Facility (NY); Step by Step providing re-entry planning for the St Lawrence County jail (NY), and the Broward Regional Health Planning Council's Forensic Reintegration Team, providing re-entry planning from the jail to the community (FL).

Monahan, J., Steadman, H. J., Silver, E., Appelbaum, P. S., Robbins, P. C., Mulvey, E. P., et al. (2001). *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder.* New York:Oxford University Press.

Morris, S. M., Steadman, H. J., & Veysey, B. M. (1997). Mental health services in United States jails: a survey of innovative practices. *Criminal Justice and Behavior* (24)1.

Moses, D. J., Reed, B. G., Mazelis, R., & D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-occurring Disorders: Experiences from the SAMHSA Women With Alcohol, Drug Abuse and Mental Health Disorders Who Have Histories of Violence Study.* Delmar, NY: Policy Research Associates, Women, Co-Occurring Disorders and Violence Study Coordinating Center.

NAMI. (2004). Housing and homelessness. *Issue Spotlights*, January. Retrieved from www.nami.org.

National Association of State Mental Health Program Directors. *State Mental Health Agency Operation and Funding Of Community Mental Health Services*. Retrieved 2005 from www.nasmhpd.org.

Office of Minority Health, Public Health Service, U.S. Department of Health and Human Services. (2000). *Assuring Cultural Competence In Health Care: Recommendations For National Standards And An Outcomes-Focused Research Agenda*. Retrieved from www.omhrc.gov.

O'Hara, A., & Miller, E. (2001). *Priced Out in 2000: The Crisis Continues*. Boston: Technical Assistance Collaborative, Inc.

Osher, F., & Levine, I. (2005). Navigating the Mental Health Maze: A Guide for Court Practitioners. New York, NY: Council of State Governments.

Osher, F., Steadman, H. J., & Barr, H. (2002). *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*, Delmar, NY: The National GAINS Center.

Peters, R. H., & Hills, H. A. (1997). Intervention Strategies for Offenders with Co-occurring Disorders: What Works? Tampa, Fl: Louis de la Parte Florida Mental Health Institute, Department of Mental Health Law and Policy.

President's New Freedom Commission on Mental Health. (2003) *Achieving the Promise: Transforming Mental Health Care in America, Final Report*. (DHHS Pub. No. SMA-03-3832) Rockville, MD: U.S. Department of Health and Human Services.

Reuland, M. (2004). *A Guide to Implementing Police-Based Diversion Programs for People With Mental Illness.* Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion.

Rold, W. J. (2003). Special needs and mental health care: a closer look. *CorrectCare*, National Commission on Correctional Health Care, Winter Issue.

Rotter, M. R., Larkin, S., Schare, M. L., Massaro, J., & Steinbacher, M. (1999) *The Clinical Impact of Doing Time*. Bronx, NY: SPECTRM Project.

Skeem, J., Encandela, J., & Louden, J. E. (2003). Perspectives on probation and mandated mental health treatment in specialized and traditional probation departments. *Behavioral Sciences and the Law* 21(4).

Skeem, J., & Petrila J. (2004). Problem-solving supervision: specialty probation for individuals with mental illness. *Court Review*, Winter Issue.

Social Security Administration. (nd). *Benefit Eligibility Tool*. Retrieved 2005 from http://best.ssa.gov.

Social Security Administration. (2001). *Social Security Disability Benefits*, Publication No. 05-11000. Retrieved from www.ssa.gov.

Social Security Administration. (2002). *Social Security Supplemental Security Income*, Publication No. 05-10029. Retrieved from www.ssa.gov.

Solomon, P. (2004). Peer support/peer provided services: underlying processes, benefits and critical ingredients. Psychiatric Rehab Journal (27(4).

Steadman, H. J., Morris, S. M., & Dennis, D. L. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. *American Journal Of Public Health*, 85: 1630-1635.

Steadman, H. J., & Morrissey J. (2002). Jail Medicaid study: Overcoming barriers for specific populations. Delmar, NY: Policy Research Associates, Inc. (unpublished).

Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services*, 52(2).

Substance Abuse and Mental Health Services Administration (nd). *Evidence Based Practices: Shaping Mental Health Services Toward Recovery*; Retrieved January 2005 from www.mentalhealth.samhsa.gov.

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women: 1 pretrial jail detainees. *Archives Of General Psychiatry* 53:505-512.

U.S. Department of Health and Human Services. (2000). *Mental Health: A Report of the Surgeon General*. Retrieved from www.samhsa.org

U.S. Surgeon General. *Executive Summary: Mental Health: Culture, Race and Ethnicity; A Supplement To Mental Health: A Report Of The Surgeon General*. Retrieved September 14, 2001 from at www.samhsa.org.

Veysey, B. (1997). *Specific Needs of Women Diagnosed With Mental Illnesses in U.S. Jails*. Delmar, NY: The GAINS Center.

Watkins, K. E., Burnam, A., Kung, F., & Paddock, S. (2001). A national survey of care for persons with co-occurring mental and substance use disorders. *Psychiatric Services* 52(8).

## Resources

The Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion provides publications that may be useful to criminal justice and mental health professionals who work with people with mental illness and co-occurring disorders.

*Non-Specialty First Appearance Court Models for Diverting Persons with Mental Illness: Alternatives to mental Health Courts.* J. Clark (2004)

*A Guide to Implementing Police-Based Diversion Programs for People With Mental Illness.* M. Reuland, (2004)

*Working With People With Mental Illness Involved In The Criminal Justice System; What Mental Health Service Providers Need To Know*, 2nd Edition. J. Massaro, 2004.

**TAPA Center for Jail Diversion**
**345 Delaware Avenue, Delmar, NY 12054**
**Toll-free: 866-518-TAPA (8272)**
**Fax: 518-439-7612**
**E-mail: tapacenter@prainc.com**

**www.tapacenter.org**
**www.gainscenter.samhsa.gov**